Declaration of Domestic Partner Relationship

Note for opposite-gender partners: ***Your signature on this document may be considered proof of a common-law marriage which carries the same rights and responsibilities as a solemnized marriage.***

Employee Name_____ Social Security #_____

Employing Agency/Branch_____ Employee ID#_____

This form must be attached to a State of Montana Employee Group Benefits Plan Enrollment/Change Form.

Partner's Name _____ Partner's Social Security # _____

Declaration

We, the undersigned, being of lawful age, attest to the following facts:

1. We are both at least 18 years of age;
2. We share a primary place of residence;
3. Neither of us is legally married to another person;
4. Neither of us is related to the other as a parent, brother or sister, half brother or half sister, niece, nephew, aunt, uncle, grandparent, or grandchild;
5. We have a financially-interdependent relationship as evidenced by at least one of the following:
    a. Mutually-granted powers of attorney or mutually-granted health care powers of attorney;
    b. Designation of each other as primary beneficiary in wills, life insurance policies, or retirement plans;
6. The following are the natural or legally adopted children of one or both of us:

_____; _____; _____;

I understand and acknowledge that the State reserves the right to request copies of all of the necessary eligibility documents. If I fail to provide the copies when requested, I understand that medical insurance coverage for the named domestic partner and dependents whose eligibility is caused by the domestic partner will be immediately terminated.

I affirm that the assertions made herein are true and correct under penalty of prosecution.

Notification of Change in or Termination of Relationship

I agree that if the domestic partner relationship as designated above no longer exists, I will notify the State Employee Benefits Plans by completing a Domestic Partner Dissolution form and **submitting to the bureau within 63 days of such change**. I understand that in the event my domestic partnership no longer exists, the signature of my partner will be required to discontinue coverage for my partner and any other qualifying dependents and that without my partner's signature I will only be able to make changes to my coverage during annual change or if I experience a qualifying event.

_____

Employee Signature Date

_____

Partner Signature Date